

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

SEP 20 1934

1. PLACE OF DEATH

County Kansas City Mo.Registration District No. 399Township NorthPrimary Registration District No. 1002City Jackson(No. RESEARCH HOSPITAL St. ADRESSA Ward MO)File No. 29497Registered No. 3018

2. FULL NAME

Miss Sally Mc Glathery(a) Residence, No. ADRESSASt. MOWard MO

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

da. 3

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

April 9 - 1874

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

60413

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

School Teacher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

April 1, 1934

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Carroll Co Mo.

MOTHER

13. NAME

Samuel Mc Glathery

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

15. MAIDEN NAME

Berlin York

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Missouri

17. INFORMANT (ADDRESS)

Justine Mc Glathery
Adressa Mo

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Adressa Mo.

DATE

8-24

1934

19. UNDERTAKER (ADDRESS)

B. Lineer & Son
Carroll Co Mo.

20. FILED

21 1934 Mr. Brown
Registrar

2 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR)

Aug 22, 1934

22. I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1934, to Aug 22, 1934I last saw her alive on Aug 22, 1934. Death is saidto have occurred on the date stated above, at 4:30 A.M.

The principal cause of death and related causes of importance were as follows:

Strangulated rt. inguinal
hernia
1224 12701
112

Date of onset

8/18/34

Other contributory causes of importance:

bronchial asthmamany
years
duration

Name of operation

rt. inguinal herniorrhaphyDate of 8-20-34What test confirmed diagnosis? operation Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) W. G. Drick(Address) Research Hospital, Kansas City Mo.

M. D.

